terrible right before an abortion because they have the symptoms of pregnancy; they have the stress of this difficult decision. We found that everybody got better rapidly and had much improved functioning a month later. Medical and surgical patients were equal to each other in a rapid improvement. Therefore I think it is very important that we should all accept this as a great option for women to have as soon as possible.

Laura MacIsaac, M.D.
Director of Family Planning
Albert Einstein College of Medicine

I am Laura MacIsaac; I am in a private practice at Albert Einstein College of Medicine, doing general Ob and Gyn. I am also the director of the Family Planning and Abortion service there. Prior to this move I was medical director at Planned Parenthood, the Margaret Sanger Center where I oversaw medical abortion with Methotrexate and provided and taught surgical abortion. I wanted to give my perspective as a busy clinician, doing the full range of Ob/Gyn services being particularly well educated and skilled in abortion matters.

The availability of mifepristone will change so much of the whole dialogue about fertility awareness for the general Ob/Gyn physician and her patients by encouraging women to make their pregnancy decisions early and by that virtue in itself, medical abortion with mifepristone is far safer than anything that we do now.

Part of my big push at Planned Parenthood was to institute early abortion surgically. We started the methotrexate abortions and we are waiting eagerly for mifepristone. At Albert Einstein at Montefiore, I am designing a new approach to teaching fertility for women. I believe the focus should be on making preventive decisions such as contraception and emergency contraception early and making their pregnancy decision early. If the restrictions on mifepristone become unwieldy, the entire benefit of giving out female patients the chance to make these decisions early will be removed for both early surgical and early medical abortion.

From the overall safety view, the longer any abortion waits the higher the morbidity associated with the procedure. And with almost everything that we do, the success of most of our interventions depends on our patient counseling and patient selection. So, all of the concerns people are worried about starting a medical abortion and not finishing it, is absolutely nothing new. It is what I do everyday with every patient. For example, sometimes when I start a surgical abortion I might have to put in dilators a day or two earlier. That starts her abortion and it is all the education and counseling that completes the procedure. The decision is made and we have to see it to the end. So all of the sort of

paranoia about some of the risks of mifepristone abortion are so minimal compared to what I do every day with all my other clinical problems.

The idea of a woman miscarrying at home in less than seven weeks is one of the most common things I get called for in the middle of the night. Its just sort of bread and butter Ob. Managing it safely is what we are all trained to do. Everyday we deal with these other little glitches of going through with the abortion procedure because of potential follow up issues. This is standard for everything we do, whether it is with surgical abortion or half of the other interventions that we do in regular clinical practice. I feel that the wave of paranoia about mifepristone in the scope of everyday practice is just not rational. Its implementation will make what I do, my specialty in fertility, so much easier and safer.

Linda Prine, M.D.
Family Practitioner, PPNYC Abortion Provider
Access Project

Today I would like to address the proposed FDA restriction requiring that medical abortion providers be trained in surgical abortions for the reasons of "safety". Being a family physician, and also surgical abortion provider at Planned Parenthood of New York City, I speak from experience.

In the world of family practice medicine, most of what we do is initiate treatments for patients who may need more specialized care at a later time. For example, we treat patients with heart pain by prescribing them medication. If they later need more extensive treatment like surgery, we refer them to a cardiac surgeon. Another example: we can deliver babies, but we cannot perform cesarean sections on those patients. We would refer these patients to an Ob/Gyn. These referrals to these specialists are a routine part of family practice. And it is part of our medical routine to have this type of back-up plan for everything that we do in case a different type of intervention is needed. This is part of our medical training - knowing when to refer the patient to a specialist.

I do not know that a government agency, especially the FDA, has ever dictated to the medical community that primary care doctors cannot initiate any medical treatment because it may later (in a small percentage of cases) need specialty care. If this proposed requirement, that medical abortion providers be trained in surgical abortion, were applied to other areas of medicine, the primary care doctor would not be able to treat the patient for heart pain with medication or deliver a baby.

Further, primary care doctors are actually the best ones to initiate medical treatments with patients, not the specialists. We already know our patients and their families, and we are aware of all of the counseling issues that will need to